STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155202	A. BUILDING 01 B. WING	06/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF GREENCASTLE, THE	1601 HOSPITAL DR GREENCASTLE, IN46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/06/11 Facility Number: 000109 Provider Number: 155202 AIM Number: 100266290 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Greencastle was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000	Preparation and\or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and\or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 100 and had a census of 86 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/08/11. The facility was found not in compliance with the aforementioned requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the door to 1 of 5 hazardous areas such as the kitchen was equipped with a	K0029	It is the intent of this facility to ensure all hazardous areas are equipped with a device arranged to automatically close the door or close the door upon activation of the fire alarm system. 1. Action Taken a. A self-closing device	06/21/2011

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	device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice affects occupants in the center smoke compartment with a census of 20 residents. Findings include: Based on observation with the administrator on 06/06/11 at 11:50 a.m., the dining room was open to the corridor. One of two doors opening into the dining room from the kitchen had no self closer. The administrator said at the time of observation, she didn't know the self closer was needed. 3.1-19(b)		has been installed on the dining room door to meet set standards. Upon activation of the fire alarm, the door will release and self-close. 2. Others Identified a. No other findings3. Systems in Place a. Upon activation of the fire alarm, the door will release and self close.4. Monitoring a. The Maintenance Supervisor\Designee will monitor door for proper operation on morning rounds. b. The CEO\Designee will review the results of the monitoring at the quarterly QA meetings with Medical Director.5. This plan of correction constitutes our credible allegation of compliance with all regulatroy requirements. Our date of compliance is 6-21-2011.	
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on observation, record review and interview; the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 86 of 86 residents. This deficient practice could affect all occupants.	K0048	It is the intent of this facility to ensure a written plan or the protection of all patients and for their evacuation in the event of an emergency.1. Action Taken a. The facility does have a policy in place for battery-powered smoke detectors (See Attachment A). b. The facility will complete a refresher inservice to all staff	06/21/2011

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	Findings include: Based on observations with the administrator between 11:15 a.m. and 2:30 p.m. on 06/06/11, individual smoke detectors were located in resident rooms. A review of the facility's Fire Plan and Fire Drill Reports with the administrator on 06/06/11 at 1:30 p.m. did not include a procedure for a specific response to a battery powered smoke detector alarm. The administrator said at the time of record review, she thought a plan was written but she was unable to locate one. She knew of no fire drill or other training event for staff which provided for a special response to activation of battery powered smoke detectors. 3.1-19(b)		members on how to respond to a battery-powered smoke detector alarm. 2. Others Identified a. No other findings. 3. Systems in Place a. The Maintenance Supervisor\Designee will review the policy with staff during monthly fire alarm drills. 4. Monitoring a. The CEO\Designee will review the results of the inservice and drills with Medical Director in quarterly QA meetings.5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 6-21-2011.	